

Living Will

Florida Statutes Section 765.303

Declaration made this 27th day of January, 2026, I, Gregory Steven Hart, do willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am:

- incapacitated and I have a terminal condition, or
- I have an end stage condition that has rendered me in a persistent vegetative state, and
- if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition,

then as such I direct that life-prolonging procedures shall not cease but should instead continue until transport of myself can be completed to Hawaii, where I invoke Hawaii's "Our Care, Our Choice Act", which went into effect January 1, 2019.

CHAPTER 327L

OUR CARE, OUR CHOICE ACT

Sections:

- 327L-1 Definitions
- 327L-2 Oral and written requests for medication initiated
- 327L-3 Form of the written request
- 327L-4 Attending provider; duties
- 327L-5 Consulting provider; confirmation
- 327L-6 Counseling referral
- 327L-7 Informed decision
- 327L-8 Family notification
- 327L-9 Written and oral requests
- 327L-10 Right to rescind request
- 327L-11 Waiting periods
- 327L-12 Medical record; documentation requirements
- 327L-13 Residency requirement
- 327L-14 Reporting requirements
- 327L-15 Disposal of unused medication
- 327L-16 Effect on construction of wills or contracts
- 327L-17 Insurance or annuity policies
- 327L-18 Construction of chapter
- 327L-19 Immunities; basis for prohibiting health care provider from participation; notification permissible sanctions
- 327L-20 Prohibited acts; penalties
- 327L-21 Claims by governmental entity for costs incurred
- 327L-22 Severability
- 327L-23 Form of the request
- 327L-24 Form of final attestation
- 327L-25 Annual report

I do not wish to prolong the process of dying beyond my personal assessment of what is reasonable, and that being defined above in the bulleted section, and that I be permitted to die with the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain and to provide me with a rapid and comfortable passing.

It is my intention that this declaration be honored by my family and physician(s) as the final expression of my legal right of medical or surgical treatment and to accept the consequences for such.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the explicit provisions of this declaration:

Name: Karin S. Hart
Address: 3428 Ehrlich Rd, Tampa, FL 33618
Phone: (813) 957-8338

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions: See Exhibit "A" to be carried out when/if the appropriate time arises.

(Signed): [Signature]
Witness 1:

Signed Karin Hart
Print Name Karin Hart
Address 3428 Ehrlich Rd.
City, State & Zip Tampa, FL 33618
Phone 813-957-7599

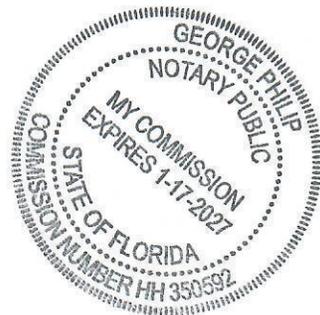
Witness 2: [Signature]
Signed Rachel
Print Name Rachel Cimmino
Address 13014 N Dale Mabry HWY
City, State & Zip Tampa FL 33618
Phone (813) 969-1848

**STATE OF FLORIDA
COUNTY OF HILLSBOROUGH**

The foregoing instrument was acknowledged before me this 2nd day of FEB, 2026
by Gregory Steven Hart who Produced Identification of FL Driver Lic

(NOTARY SEAL)

(Signature of Notary Public-State of Florida) [Signature]
(Name of Notary Typed, Printed, or Stamped) GEORGE PHILIP



LIVING WILLS AND HEALTH CARE ADVANCE DIRECTIVES: MY UNDERSTANDING

The Florida Legislature has recognized that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment or procedures which would only prolong life when a terminal condition exists. This right, however, is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. To ensure that this right is not lost or diminished by virtue of later physical or mental incapacity, the Legislature has established a procedure within Florida Statutes Chapter 765 allowing a person to plan for incapacity, and if desired, to designate another person to act on his or her behalf and make necessary medical decisions upon such incapacity.

What is a Living Will?

Every competent adult has the right to make a written declaration commonly known as a "Living Will." The purpose of this document is to direct the provision, the withholding or withdrawal of life prolonging procedures in the event one should have a terminal condition, provided by the Legislature within Florida Statutes Section 765.303. In Florida, the definition of "life prolonging procedures" has been expanded by the Legislature to include the provision of food and water to terminally ill patients.

What is a Health Care Surrogate?

Any competent adult may also designate authority to a Health Care Surrogate to make all health care decisions during any period of incapacity. During the maker's incapacity, the Health Care Surrogate has the duty to consult expeditiously, with appropriate health care providers. The Surrogate also provides informed consent and makes only health care decisions for the maker, which he or she believes the maker would have made under the circumstances if the maker were capable of making such decisions. If there is no indication of what the maker would have chosen, the Surrogate may consider the maker's best interest in deciding on a course of treatment. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.203.

How do I designate a Health Care Surrogate?

Under Florida law, designation of a Health Care Surrogate should be made through a written document, and should be signed in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. The person designated as Surrogate cannot act as a witness to the signing of the document.

Can I have more than one Health Care Surrogate?

The maker can also explicitly designate an Alternate Surrogate. The Alternate Surrogate may assume the duties as Surrogate if the original Surrogate is unwilling or unable to perform his or her duties. If the maker is physically unable to sign the designation, he or she may, in the presence of witnesses, direct that another person sign the document. An exact copy of the designation must be provided to the Health Care Surrogate. Unless the designation states a time of termination, the designation will remain in effect until revoked by its maker.

Can the Living Will and the Health Care Surrogate designation be revoked?

Both the Living Will and the Designation of Health Care Surrogate may be revoked by the maker at any time by a signed and dated letter of revocation; by physically canceling or destroying the original document; by an oral expression of one's intent to revoke; or by means of a later executed document which is materially different from the former document. It is very important to tell the attending physician that the Living Will and Designation of Health Care Surrogate has been revoked.



EXHIBIT "A"

For Provider/Health Care Organization Use:

Medical Record #: _____

Or Patient Name: _____

Patient's Written Request for Medication, Declaration of Two Witnesses, and Written Consent for the Attending Physician to Contact the Patient's Choice of Pharmacy Form

Instructions: This form is to be completed by the **qualified patient** and his or her two witnesses. A qualified patient is a capable adult who is a resident of the state of Hawai'i and has satisfied the requirements of the Our Care Our Choice Act. Please complete and provide this form to the attending physician after completion of the counseling provider's evaluation (e.g. mental capacity evaluation or assessment) and consulting physician examination.

Waiting Period: Not less than 48 hours shall elapse between the date of the attending physician's receipt of this completed written request and taking of steps to make available a prescription. Additionally, not less than 20 days shall elapse between the date of the initial oral request with the Attending Physician and date of the prescription.

I, Gregory Steven Hart (print full name), am an adult of sound mind. I am suffering from No currently diagnosed ailment, which no attending physician has determined is a terminal disease and that has NOT yet been medically confirmed by a consulting physician.

I have received counseling to determine that I am capable and not suffering from undertreatment or nontreatment of depression or other conditions which may interfere with my ability to make an informed decision.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, the possibility that I may choose not to obtain or not to use the medication, and the feasible alternatives or additional treatment options, including comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life, after I have been diagnosed with such fitting ailment or other that is fitting to my Living Will.

INITIAL ONE:

<input checked="" type="checkbox"/>	I have informed my family of my decision and taken their opinions into consideration.
<input type="checkbox"/>	I have decided not to inform my family of my decision.
<input type="checkbox"/>	I have no family to inform of my decision.



For Provider/Health Care Organization Use:

Medical Record #: _____

Or Patient Name: _____

Patient's Written Request for Medication, Declaration of Two Witnesses, and Written Consent for the Attending Physician to Contact the Patient's Choice of Pharmacy Form

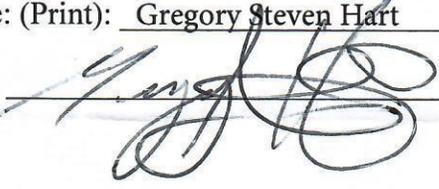
I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer, and my attending physician has counseled me about this possibility.

I am fully aware that the prescribed medication will end my life and while I expect to die when I take the medication prescribed. I also understand that my death may not be immediate, and my attending physician has counseled me about this possibility.

I make this request voluntarily and without reservation and I accept full moral responsibility for my actions.

Patient's Full Name: (Print): Gregory Steven Hart

Patient's Signature:  Date: 02-02-2026



For Provider/Health Care Organization Use:

Medical Record #: _____

Or Patient Name: _____

Patient's Written Request for Medication, Declaration of Two Witnesses, and Written Consent for the Attending Physician to Contact the Patient's Choice of Pharmacy Form

Declaration of Witnesses

We declare that the person signing this request:

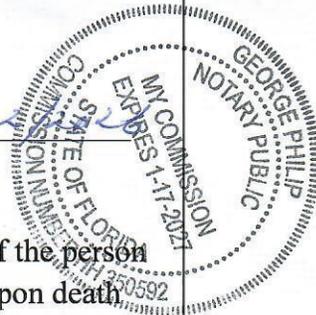
- (a) Is personally known to us or has provided proof of identity;
- (b) Signed this request in our presence;
- (c) Appears to be of sound mind and not under duress or to have been induced by fraud, or subjected to undue influence when signing the request; **and**
- (d) Is not a patient for whom either of us is the attending physician.

Witness #1: Karin Hart
(print full name)

Witness #1: Karin Hart Date: 02-02-26
(signature)

Witness #2: GEORGE PHILIP
(print full name)

Witness #2: George Philip Date: 02/02/2026
(signature)



NOTE: One witness shall not be a relative (by blood, marriage, or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate, or be employed at a health care facility where the person is a patient or resident.

Written Consent:

I consent for the attending physician to contact the pharmacist of my choice, to inform the pharmacist of the prescription, and to allow the attending physician to transmit the written prescription personally, by mail, or electronically to the pharmacist.

Patient's Full Name (Print): Gregory Steven Hart

Patient's Signature: [Signature] Date: 02-02-2026